Indiana Department of Education

Center for School Improvement and Performance
Office of Student Services
State Attendance Officer
Room 229, State House
Telephone: 317/232-9132

Certificate of Incapacity
(Note: I.C. 20-8.1-3-20 requires this form to be signed by a licensed physician)

Students's Name ____
(Last) (First) (Middle)

Grade_______Date of Birth___________Social Security Number (optional)__________-_____-__________

School________________________________Principal___________________________ Telephone Number (____)______________________

Part 1 (To Be Completed By The Physician)

Diagnosis or Description of the Condition____
____
____

Duration of the Condition (Check One):__________permanent__________temporary

Anticipated Date the Student May Return to School:____________________, 20____.

Date Student Should Return for Re-examination:______________________, 20____.

Part 2 (To Be Completed By The Physician)

Based on your diagnosis and professional judgment, the school should anticipate the student's attendance to be (check one):

____________________Regular Daily Attendance

____________________Irregular Daily Attendance (please explain)
____
____
____

_________________Seasonal (please explain)
____
____

If an individualized program is warranted due to anticipated irregular school attendance or restriction of physical activities, the school may submit a written individualized program for the physician's approval and signature.

Return form to:
____
____
____
____
____
Telephone Number

____
Physician's Signature

____
Physician's Printed Name

____
Physician's Address

____
Telephone Number